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Parent Perspectives of Perceived Racial Bias in their Adolescent's Healthcare Experience in Emergency Rooms

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Cover Page Footnote

Thank you to the Olivet Honors Program for providing the tools and the environment to pursue my passions. I will always be thankful for the things I have learned throughout my experience in the program: the will to persevere, the passion to remain curious, and the humility to ask for help. Thank you to my mentor, Dr. Yvette Rose. Your wisdom and knowledge of the medical field was invaluable to my research, and I could not have finished this project without your assistance and encouragement. Thanks also to Dr. Beth Schurman and Dr. Dan Sharda who both walked me through the research process and who lent such important advice. To my friends and family, you believed in me when I didn't believe in myself, and I am forever indebted to you for your constant encouragement and love. Your texts and hugs encouraged me to keep pressing on towards my goals, and I truly couldn't have done any of this without you. Thank you.



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Ashleigh E. Godby

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ABSTRACT

Background

Research reports that health outcomes are not equal among individuals in the United States. For instance, maternal death rates are higher for Black women than for White (Rabin, 2019). Such healthcare disparities are not limited to adult healthcare. Some research indicates evidence of disparity in pediatric prescriptions and diagnoses of certain illnesses in Black children versus non-Black children (Gerber et al., 2013). Additionally, research has been published discussing the prevalence of implicit bias in health care and how such bias impacts implementation of medical care (Gerber et al., 2013; Wisniewski & Walker, 2020; Sabin & Greenwald, 2012). A review of literature found no qualitative studies discussing the parent perspectives of perceived racial bias in their child's healthcare in emergency departments. This study seeks to fill this gap in the research by using a qualitative method of interviewing mothers of minority children and mothers of White children to investigate the levels of perceived racial bias in their adolescents' previous emergency room visits.

Methods

Perceived bias was assessed by interviewing 10 mothers of minority children and 9 mothers of White children. Participants included mothers from Illinois, South Carolina, Tennessee, and Texas. An 11-item semi-structured interview guide was used in order to discover participants' perceptions of their child's emergency room care. Two questions from the Commonwealth Fund's 2001 Health Quality survey were used to assess participants' views on discrimination in healthcare and life in the United States. Interviews were transcribed and analyzed utilizing in-vivo and general inductive coding methods.

Results

Mothers of minority children did not perceive negative medical treatment of their children; however, 40% of mothers of minority children felt misunderstood because of race or something cultural about them. Further codes or themes of participant interviews included: Familiarity with Emergency Room Staff, Insurance, and Privilege. Mothers of minority children perceived higher levels of discrimination in healthcare and general minority discrimination than mothers of White children.

Conclusions

Some surveyed mothers of minority children perceived racial bias and cultural misunderstanding in their adolescents' care in emergency rooms. Though mothers of minority children did not necessarily feel as though their children received lower levels of care due to race, it is important to note how perceptions of bias and cultural misunderstandings affect minorities' perceptions of their child's healthcare.

Keywords: parent perspectives, racial bias, perceived bias, minority healthcare

REVIEW OF LITERATURE

Racial Disparities in Healthcare

Racial bias and disparities have been studied extensively over the years, and perceptions of bias have been reported by Black patients as recently as 2018 (Gonzalez et al.). These disparities are not fully explained by differences in access, clinical appropriateness, or patient preferences (Johnson et al., 2004). This means that differences in the implementation of healthcare among ethnic minorities is tied to a broader systematic bias, economic inequality, and prejudice (Johnson et al., 2004). The findings of the 2018 National Healthcare Quality and Disparities Report noted the persistence of healthcare disparities, especially in poor and uninsured populations. This national survey, mandated by Congress, provided an overview of the quality of healthcare received by the U.S. population. Reported disparities in quality measures included: person-centered care, patient safety, healthy living, effective treatment, care coordination, and affordable care. Specifically, in 40% of healthcare quality measures, the report found that Blacks, American Indians and Alaska Natives, and Native Hawaiians/ Pacific Islanders received worse healthcare quality than Whites. Additionally, Hispanics had poorer healthcare than Whites in 35% of healthcare quality measures and Asians received poorer healthcare quality in 27% of measures. However, Asian populations reportedly had better care than Whites in 28% of healthcare quality measures (National Healthcare Quality and Disparities Report, 2018). The pervasiveness of this issue has caused divides in quality of health care, and it is important to continue discovering how to address and mend the issue.

In May of 2019, the *New York Times* published findings about racial disparities in pregnancy-related deaths in Black women versus white (Rabin, 2019). Results showed Black women are 3.3 times more likely to die of a pregnancy related death than White women. A factor in this statistic is the major cause of deaths: cardiovascular disease. Black women suffer disproportionately from cardiovascular disease. In order to prevent avoidable deaths, gaps, like differences in factors such as heart health, should be identified and assessed while any patient is under care (Rabin, 2019).

There have also been documented disparities in pain management among minority patients (Todd et al., 2000). Black patients, when compared to White, are given lower dosages of pain medication. It is thought that such disparities may be attributed to false beliefs physicians have about biological differences between White and Black patients (Hoffman et al., 2016). To analyze this further, Hoffman, Trawalter, Axt, and Oliver assessed physicians' beliefs about biological differences and the effects on treatment recommendations (2016). Participants in this study read medical scenarios of both White and Black patients and rated the patient's prospective pain level and made treatment recommendations. Additionally, participants took a survey assessing false beliefs about biological differences between Black and White individuals. For instance, one false belief statement was, "Blacks' nerve endings are less sensitive than Whites". About 50% of medical students and physicians rated at least one of these false statements as true or probably true. Individuals who had false beliefs rated a Black person's pain as lower and made less accurate treatment recommendations than

those who did not hold false beliefs about biological differences. This study determined that some individuals with medical knowledge may hold false beliefs about biological differences between races, and this could have an impact on healthcare treatment of minority patients (Hoffman et al., 2016).

Perceived Bias in Healthcare

Additional studies, like that of Johnson et al. (2004), show disparities in the perception of healthcare of Black patients in comparison to White patients. Researchers surveyed 6,000 adults and asked questions like, “Do you believe your medical care would have been better if you were a different race?” The results showed that a statistically significant percentage of African Americans believed that they would receive better health care if they were a different race and that medical staff judged them based on their race. African Americans reported having lower levels of respect for their provider and less time spent with the provider than White patients (Johnson et al., 2004). Additionally, in a study conducted by Campesino, Saenz, Choi, and Krouse, 56% of African Americans disagreed with the statement, “Most people in the United States receive the same quality of healthcare regardless of their racial background or language spoken” (2012). In qualitative interviews, 36% of those interviewed perceived discrimination in quality of health care due to race or ethnicity, Spanish language, skin color, citizenship status, or having low income.

A 2018 study interviewed 74 participants with an interview guide that focused on racial and ethnic bias (Gonzalez, Deno, Kintzer, Marantz, Lypson, & Mckee). In their findings, some participants who perceived bias had lower levels of trust in their provider and delayed seeking future medical care. However, the researchers concluded that some instances of perceived bias could still lead to positive outcomes. This depended on whether or not the physician acknowledged the bias and made subsequent behavioral changes. Differences in healthcare implementation might be remedied by an increase in cultural competence. This is accomplished when a healthcare provider adjusts and recognizes the differences in order to better understand the culture of the patient (Johnson et al., 2004).

Racial and Ethnic Disparities in Pediatric Health and Healthcare

Flores reviewed literature over a 57-year period and noted the persistence of disparities in the healthcare of children (Flores, 2010). The review noted disparities in the healthcare of children related to mortality rates, access to care and use of services, prevention and population health, chronic diseases, special healthcare needs, and quality of care. Racial and ethnic minorities had a greater risk of death from drowning, acute lymphoblastic leukemia, and after congenital heart defect surgery than White children. This review of literature reveals the historic pervasiveness and persistence of racial and ethnic disparities in the health and healthcare of minority children (Flores, 2010). Gerber and others, in their study of the prescription of antibiotics, added to the evidence of the racial differences in the medical treatment of children (Gerber et al., 2013). The study provided strong statistical evidence for the disparity in pediatric prescriptions and diagnoses of certain illnesses in Black children versus non-Black children. Specifically, their results concluded that Black children were less likely to

receive a prescription for antibiotics, namely broad-spectrum, than non-Black children even when a prescription of antibiotics was justified (Gerber et al., 2013).

In addition to disparities in the prescription of antibiotics, there has been documented evidence for racial disparities in pain management (Todd et al., 2000). A 2015 study conducted by Goyal et al. reported evidence of racial disparity in pain management in children as well. This study analyzed a national sample of visits to the emergency department for associations between race and prescription of nonopioid and opioid analgesic medication among pediatric patients. Black patients with moderate pain were less likely to receive any analgesia when compared to White patients (15.7% versus 58.5%), and Black patients with severe pain were 34% less likely to receive opioids than White patients. Additionally, Black children with appendicitis had one fifth the odds of receiving a prescription for opioids than White children. The researchers made note that the rate of opioid prescription among children with appendicitis is typically low, but the results of this study showed evidence of racial disparity among children who received opioid analgesia. Over the seven-year period of data analysis, racial disparities in opioid prescription persisted (Goyal et al., 2015).

A current study of pediatric healthcare revealed the persistence of disparities in the care of children in the emergency department (Zhang et al., 2019). Researchers analyzed data from the National Hospital Ambulatory Medical Survey (NHAMCS) in order to investigate racial and ethnic disparities in the health outcomes of children. The study estimated the association of the Emergency Severity Index (ESI) and race. The ESI scale categorizes patients on a scale of 1 to 5 with 1 being the most urgent and 5 being the least urgent. The data showed disparities among the treatment of minorities regarding factors such as wait times, ESI score, and medical resource utilization. Hispanic and Black children had significantly longer wait times in the ED compared to White children as well as longer visit times. Black and Hispanic children were less likely than Whites to be classified as needing immediate or urgent care, and this was not fully explained by demographic, socioeconomic, or clinical variables. Additionally, Black, Hispanic, and Asian children were significantly less likely than Whites to receive blood tests, X-rays, and CT scans. Disparities in pediatric ED care persisted over the study period for Black and Hispanic patients and not for White and Asian children (Zhang et al., 2019).

A study conducted by Stockwell et al. (2019) assessed the association of the race and insurance status of pediatric patients and the severity of adverse events (AEs). Adverse events include any incident that results in harm to a patient and range in severity from mild to severe. The researchers concluded that Latino children showed a significant difference in adverse events, including preventable and high severity, when compared to White patients. Additionally, children with public insurance had significantly higher AEs than privately insured children. These findings are evidence of how socioeconomic status and race might affect healthcare outcomes in children (Stockwell et al., 2019).

Flores surveyed parents by telephone in order to assess the health and healthcare quality of children (2005). Minority parents were less likely to report their child as having

“excellent” or “very good” health. For instance, 90% of White parents gave ratings of “good” or “excellent” when asked about their child’s health. Black and Hispanic parents gave high health ratings only 79% and 72% of the time, respectively. White children were more likely to have “well” visits in private or group practices, whereas minority children were more likely to receive care in health centers or public clinics with an assigned provider. Additionally, minority parents, more so than White parents, reported their child’s healthcare provider “never” or “only sometimes” respected them as the expert on the child. This study’s results also identified concerns with healthcare providers contributing to the stereotyping of minorities. This concern was evidenced in that minority parents were three times more likely than White parents to report instances where their provider discussed things such as, community violence, household smoking, household use of alcohol or illicit drugs, and paying for the child’s basic needs. This “over-discussion” and conscious or unconscious stereotyping raises concerns about minorities interpreting these interactions with their child’s provider as discriminatory. This may lead to lower satisfaction in care and negatively affect communication between the patient and provider (Flores, 2005). Though this study noted no disparities in some areas such as overall ratings of the well- care provider, there were disparities in the overall health of minority children. Specifically, Black children were two times as likely to not be in “excellent” or “very good” health compared to White children (Flores, 2005).

Implicit Bias in Healthcare

In other studies, there have been recorded instances of bias from the physician’s perspective. Green et al. used the established Implicit-Association Test (IAT) to measure implicit bias of 220 internal medicine and emergency medicine residents in Boston, Massachusetts, and Atlanta, Georgia (2007). Though there were no significant findings of explicit or self-reported bias among physicians, there were significant findings of implicit, or unconscious, biases. In such cases of high levels of implicit bias, there were differences in the likelihood of the physician to offer thrombolysis. This study acknowledges that implicit bias might not lead to explicit racism but could lead to a portion of health care disparities (Gerber et al., 2007).

Wisniewski and Walker assessed implicit bias of race and ethnicity and its association in the scheduling practices of primary care appointments (2020). Seven females of different racial or ethnic backgrounds called primary care offices in order to schedule the next available appointment after introducing themselves with their name. White patients were asked about their insurance status 38.5% of the time whereas Black patients were asked 80.9% of the time. To eliminate variability, all of the patient callers were uninsured. Questions about status of insurance were asked by the offices most often and had the highest rates of racial and ethnic disparity. Disparity was associated with race and ethnicity and was not affected by location of the primary care office or type of healthcare provided. There was no disparity in amount of offered appointments. However, Black and Hispanic patients received later appointments than White callers. The researchers concluded that discrimination

against minorities may result in disparities with minorities' access to healthcare (Wisniewski & Walker, 2020). It is important, then, to further research how implicit biases and discrimination against minorities affects the implementation and equality of healthcare among minority populations.

In addition to recorded disparities in the healthcare of children, there has also been evidence of the association of implicit bias among physicians and the prescription of pain medication to children (Sabin & Greenwald, 2012). Implicit biases are biases against an individual that occur outside the conscious awareness and may subtly affect behavior. Sabin and Greenwald studied the association of physicians' implicit biases and treatment recommendations for children with conditions of asthma, attention deficit hyperactivity disorder (ADHD), urinary tract infections (UTI), and pain (2012). Doctors who scored highly on the IAT and had more pro-White implicit bias were more likely to prescribe pain medication to White pediatric patients than to Black patients (Sabin & Greenwald, 2012). This study provides evidence of how implicit bias and unconscious attitudes of healthcare providers affects the healthcare quality of Black children.

The US Census Bureau projects that by the year 2030 there will be more minority children than non-Hispanic White children (US Census Bureau, 1996). Therefore, it is important to further analyze and study the healthcare disparities that currently exist in the healthcare of minority children today. Many studies of racial differences in healthcare focus on technical implementation of care including diagnostic tests, procedures, and prescriptions. However, healthcare is a complex combination of interpersonal processes that can lead to perceptions of bias and discrimination (Johnson et al., 2004). Qualitative studies have been published discussing implicit bias in health care including incorporating patient perspectives. Though racial disparities in pediatric healthcare have been evidenced and reported, the review of literature found no qualitative studies discussing the parent perspectives and perceptions of racial bias in their child's healthcare in emergency departments. It is important to continue the pursuit of researching biases and racial disparities in healthcare until the issue is remedied.

METHODS

Participants

Participants involved in this study were selected through convenience sampling and were contacted through university mentors and professors. Of the 19 total participants, 16 visited emergency rooms in Kankakee, Illinois, but two participants were located in Greenville, South Carolina and one in Franklin, Tennessee. One participant currently located in Greenville, South Carolina also discussed an emergency room visit while living in Arlington, Texas. Participants included ten mothers of minority children of Black, Asian, and Hispanic race. However, three of these mothers were White with minority children. The comparative population of participants included nine White mothers of White children. Each mother was interviewed about her child's most recent emergency room visit. The age of children at the time of the emergency room

visit ranged from eight months to fifteen years. The reasons for the emergency room visits varied by participant and included instances of high fever, sutures, asthma complications, and burns. Before the analysis and coding of participant transcripts, each participant was assigned a pseudonym to protect their identity.

Materials

Materials included a semi-structured interview guide (see Appendix 1) that was modified from Gonzalez, Deno, Kintzer, Marantz, Lypson, & McKee's focus group interview guide (2018) and Campesino, Saenz, Choi, and Krouse's seventeen-item interview guide (2012). Views on perceived discrimination in healthcare and life in the United States were assessed using two questions from the Commonwealth Fund's Health Quality Survey (2001).

Procedure

Four face-to-face interviews were conducted at Second Baptist Church in Kankakee, Illinois, and Olivet Nazarene University in Bourbonnais, Illinois. Before starting the interview, participants gave written and verbal informed consent, and each participant agreed voluntarily. The audio from the interviews were recorded electronically and transcribed using the professional service, Scribie. Fifteen interviews were conducted over the phone, and consent was obtained verbally. Calls were recorded using the app "Rev Call Recorder," and participants were made aware that the call was recorded for the purpose of data analysis. Interviews ranged in length from ten to fifteen minutes.

Analysis

Saldaña's qualitative in-vivo analysis method was employed in primary readings of transcripts (2016). Specific phrases spoken by respondents were used as tentative codes or themes. The first categories created were kept tentative throughout the first and second cycle of data analysis because some categories were not the most accurate representation of themes present in all of the data. As described by Thomas, further analyses of transcripts followed the general inductive method which was characterized by a second detailed reading of interview transcripts in order to further categorize concepts and themes present in the data (2006). In the second cycle of coding, excerpts were assigned to predominant, existing codes. The themes that were most significant or most frequently present in transcripts were finalized as codes. Numerical data included ratings of level of care and two survey questions about treatment of minorities in healthcare and general minority discrimination. The mean of participants' ratings was calculated and compared between minority and White participants.

Misunderstood Because of Race or Culture

Forty percent of mothers with minority children reported feeling that she or her child was misunderstood because of race or some aspect of culture. Similar reports were found in a study conducted by Campesino et al. (2012). Thirty-six percent of their minority participants clearly perceived discrimination in their healthcare due to race or ethnicity. Participants in the present study did not use the word 'discrimination' when describing their experiences. Additionally, all mothers of minority children who perceived misunderstanding by healthcare staff rated the level of care given to their

TABLE 1

Four themes and one sub-theme determined from the in-vivo coding method with example quotations.

Theme	Sub-theme	Example Quotation
Misunderstood Because of Race or Culture		"So, it was like, they (ER staff) just didn't have the time, they just kind of shifted us to the side. I don't know if it was because he was black or because he was just a big black guy, it's a difference."
	Assumption	"Assuming by someone's, let me guess color, 'cause I don't know what else he could've went off of, what type of insurance they have is just not acceptable in this day and age. I just think it's unprofessional to just assume, and I think everyone deserves good healthcare no matter what insurance you have."
Familiarity with Emergency Room Staff		"I'm satisfied but I still always say because I worked there. I don't want to call it 'special treatment' or 'preferential treatment', but it's like when you go there, they would call you by your first name."
Insurance		"He had state insurance and so working in the healthcare field myself, I know that kids of all ages, adults of all ages, don't get the care that someone would necessarily get that has private insurance through work. So, I feel like they hold back on tests and they hold back on... It's just kind of a quick fix because they know it's the state paying for it, and I see them kind of more rushed than a child that would have good insurance."
Privilege		"My kids are of different ethnicity, but I think that they received care as if they were privileged white, because they live in a privileged white home, and in a privileged white community."

child highly. According to participants within this study, any assumption or cultural misunderstanding did not necessarily hinder the medical care given to their child. In contrast to minority participants, all nine mothers of White children stated that they had never felt misunderstood because of race during an ER visit.

Lisa, a Black mother of a Black child, took her 14-year-old son to the emergency room because he mistakenly took more than the prescribed dose of sleep-aid medication. In explaining the context of her son's treatment by ER staff, Lisa explained that her child has a behavior disorder, is "intimidatingly" tall for his age, and was particularly verbal upon arrival to the ER. When asked if she or her child had ever been misunderstood by

hospital staff due to race or culture, she responded, “Yes, because of race and culture.” When asked to expand on this experience, Lisa added, “So, it was like, they (ER staff) just didn’t have the time, they just kind of shifted us to the side. I don’t know if it was because he was black or because he was just a big black guy, it’s a difference.”

Tracy, a White mother of an Asian son, also perceived misunderstanding by ER staff due to cultural differences. However, she felt as though her child’s care was excellent. The only misunderstanding she perceived was due to the way the ER nurses medically assessed her child. Tracy’s son visited the emergency room to receive sutures after sustaining a head injury. She explained that some healthcare visits are different for him because of his race. For instance, because he has slanted, almond shaped eyes, medical assessments can differ for him versus White patients. She explained:

So, as they were doing his neuro exam and assessing his eyes that day in the ER, they’re like, ‘Open your eyes,’ and he’s like, ‘They are, can’t you see that I’m Asian?’ So eighth grade freshman year, he’s like, ‘Do they not see that my eyes don’t open like everyone else’s?’

In this case she perceived a misunderstanding but did not indicate that this interaction between her son and the ER staff was negative. Later on, however, when asked if she felt like there could have been any improvement in her child’s ER assessment, she said, “I just think that overall, we need to do a better job in treating our culturally diverse patients as a whole. We need to do a better job at that.” In her opinion, it is important for healthcare providers to understand cultural differences in order to provide the same level of care to all patients.

Assumption

Two minority participants, when asked if they or their child had ever been misunderstood because of race, noted feeling like staff had made negative assumptions about them. Both mothers included references to the color of their skin when explaining their experience with perceived assumptions. In both cases, however, assumptions were directed towards the mother more so than the child. Karen, a Black mother of a Black child, took her child to the emergency room, and the doctor prescribed medication for nausea. However, the doctor mentioned that state insurance would not provide coverage for this medication. Karen became upset because she had private insurance and not a “medical card.” Karen commented further:

If a medication works better, then that’s the medication I want her on. Assuming by someone’s, let me guess color, ‘cause I don’t know what else he could’ve went off of, what type of insurance they have is just not acceptable in this day and age. I just think it’s unprofessional to just assume, and I think everyone deserves good healthcare no matter what insurance you have.

Another Black mother of a Black child, Cherie, is a registered nurse, and in one ER visit with her child, she felt as though the nursing staff assumed she was uneducated because of the way they talked to her. She remarked:

Oh, I know one time, think it was my daughter, my 13-year-old, had a muscle spasm in her neck and she couldn't move her neck and so she (the nurse) was talking to me and my husband as we... as if we was like uneducated black people, and so we sat, I sat there, he sat there, we just listened. And I said, 'Okay, now since you're saying that I do have education,' I said, 'As a matter fact I got more education than you. So, I think you need to talk to me like you would talk to a Caucasian woman.' And so, she never did come back in there. She sent somebody else in there.

Familiarity with Emergency Room Staff

Three participants with minority children (30%) were either staff members or known by staff at the emergency room where their child was seen. Each participant who reported familiarity with hospital staff expressed their hypothesis that this relationship could have changed their child's ER experience in some way. Each participant who reported a level of familiarity with hospital staff gave high ratings for the level of care their child received (ratings of 4 or 5). Tracy, a White mother of an Asian child remarked:

...and then going to a hospital system that I worked at for years and knew the staff. I think it probably would've been different if we didn't know any of the folks. I think that we probably would've had a different experience.

Upon clarification, however, Tracy did not think that her child's experience would have necessarily been negative if she had not known the staff.

When asked, "Do you think if something were different about your child that they would receive better care?", Linda, a Black mother of Black children responded:

I'm satisfied but I still always say because I worked there. I don't want to call it 'special treatment' or 'preferential treatment,' but it's like when you go there, they would call you by your first name.

Though some participants noted how relationships with staff effect level of care, such conclusions about preferential treatment cannot be made within the parameters of this study. It is important, though, to note that familiarity with ER staff factored into how these three minority participants perceived the level of care their child received.

Insurance

When asked about their specific child's healthcare or minority healthcare discrimination, 40% of minority participants noted insurance as a factor in healthcare treatment. A similar response was given by mothers of White children. Kelly, a White mother of Black children, spoke of her child's experience on Medicaid:

I had to take my son to the emergency room. It was on Christmas Eve. And we were on Medicaid and we were poor and all that stuff. So, with Medicaid in Texas, you can only go to a specific doctor and it was like on that or you had to go to the emergency room. But the doctor's was closed over Christmas Eve and Christmas and then it was a weekend, so it was closed for four or five days in a row, but my

son came down with pinkeye and I had to get treatment for him. And I remember walking out, and I heard one of the nurses saying, 'Are you kidding me? That baby's just here for a cold?' So, I mean that instance kind of was like... really? Come on.

In this case, the participant did note that her son received the care and treatment needed, and the staff member who voiced the negative comments about her son's visit was not providing direct care. After explaining this incident, she answered "no" when asked whether or not she or her child had been negatively judged in a visit to the emergency room. In most of her past emergency room visits with her children, Kelly reported high levels of care, and the comment made about her son was a sole incident. However, experiences like Kelly's shed light on negative assumptions that occur in emergency rooms today, even if such incidences might not occur the majority of the time.

Three (33%) of mothers of White children also noted insurance as a barrier to healthcare, either in their child's or in the United States as a whole. Angela, a White mother, reported having difficulty in seeking care for herself and her children while on Medicaid. Her experience working in doctors' offices and hospitals has exposed her to instances when types insurance can affect the level of care provided to patients. When asked, "Do you think that if something were different about your child, that they would have received better care during that visit?" she replied:

Possibly. He had state insurance and so working in the healthcare field myself, I know that kids of all ages, adults of all ages, don't get the care that someone would necessarily get that has private insurance through work. So, I feel like they hold back on tests and they hold back on... It's just kind of a quick fix because they know it's the state paying for it, and I see them kind of more rushed than a child that would have good insurance.

Though types of insurance were not the original question of the present study, both minority and White participants perceived it as a factor in the level of care received. For some mothers, like Angela, there was a perceived difference in the quality of healthcare their child received based on having state insurance versus private insurance.

Privilege

One mother of a minority child (10%) perceived privilege due to race as a factor in the level of care her child received. In her case, she is a White mother of two Asian children. In explaining her perceptions of care in emergency rooms she said, "My kids are of different ethnicity, but I think that they received care as if they were privileged white, because they live in a privileged white home, and in a privileged white community." Four mothers of White children (44%) addressed their perceptions of privilege in the healthcare of themselves and their children. Each of which perceived benefit to her own healthcare as well as her child's due to their race. For instance, Emily, a White mother remarked:

My primary care provider is a Caucasian female, and all my midwives were Caucasian females, so there's a shared commonality there, and I do think it makes a difference. But having said that, I've also been seen by an Indian doctor and had a great relationship with her. But I do think the system probably favors, yeah, Caucasian people. And I have the education and information to know like... I have a medical bill right now from my son's birth that I'm gonna call and dispute, because we were charged for an out-of-network doctor when he was born, and we didn't have the option to say whether we wanted an in-network or an out-of-network doctor, and because I'm a white woman, I feel like that, I don't know, I'm listened to more probably.

Mothers who reported racial privilege noted that their race might have been a factor in the level of care their child received.

Level of Care

Mothers rated the level of care of their child's emergency room visit from 1 to 5, with 5 being the greatest level of care possible. Results are tabulated in Table 2. Mothers of minority children, on average, rated level of care 4.5 with a mean variance of 0.24. Mothers of white children rated a lower level of care with a mean of 4.17; however, this mean varied by 1, whereas mothers of minority children were more consistent with level of care ratings. The lower score given by mothers of white children may be attributed by a mother who gave a rating of 2, which was an outlier. This mother gave a lower rating because she felt as though the emergency room was not equipped to handle pediatric emergencies. The mother and child waited a "really, really long time to get in" and after three and a half hours, they left the hospital because her child's fever was reduced with Tylenol. The participant described her experience by saying:

"They're just not set up for children... it felt like they were just understaffed and there was no urgency to the matter." Forty percent of mothers with minority children did not give a rating of five, however, those who did not gave a score of 4. Mothers of minority children who did not give a care rating of 5, described various reasons for doing so.

One participant attributed the lower score to long ER wait times. Another participant gave a rating of 4 because the ER visit was the best for "what they're able to provide" for pediatric emergencies. Difference in level of care cannot necessarily be attributed to race because none of the minority participants mentioned race or ethnicity as the reason for rating their child's level of care lower than a 5.

TABLE 2

Comparison of mean values and mean variance for level of care, perceptions of healthcare equality, and perceptions of minority discrimination.

	Mean Value Mothers of Minority Children (n = 10) (\pm Mean Variance)	Mean Value Mothers of White Children (n = 9) (\pm Mean Variance)
Level of Care (out of 5, 5 being the highest)	4.5 \pm 0.24	4.17 \pm 1
“Most people in the United States receive the same quality of healthcare regardless of their racial background or language spoken.” (1 = strongly agree to 4 =strongly disagree)	3 \pm 1	2.56 \pm 0.91
“How much discrimination against minorities do you feel there is in the United States today?” (1 = none to 4 = a lot)	3.3 \pm 0.21	2.78 \pm 0.78

Perceived Healthcare Discrimination

Though 60% of the participants with minority children have never felt their child was treated differently because of race, 70% either disagreed or strongly disagreed (ratings of 3 or 4) with the statement, “Most people in the United States receive the same quality of health care regardless of their racial background or language spoken.” These data are also tabulated in Table 2.

Within this study, participants recognized racial or ethnic disparities within healthcare, even if their own experience did not reflect any negative treatment. In Campesino’s study of Latina and Black women who had been treated for breast cancer, 46% of women felt healthcare quality differed due to an individual’s spoken language or racial background (Campesino et al., 2012). Similar to the present study, participants in Campesino’s study referenced general healthcare discrimination even if they had not perceived racial discrimination in their own healthcare experience. Within Campesino’s study, Spanish-speaking Latinas gave a mean score of 2, Black women gave a mean score of 2.56, and English-speaking Latinas gave a mean score of 2.6. Within this present study, mothers of minority children gave a mean score of 3 with a variance of 1. Participants with White children gave similar scores to Campesino’s minority participants. When asked about healthcare discrimination, White participants of the present study gave a mean score of 2.56 with the mean varying by 0.91.

Three participants with minority children (30%) gave ratings of 2 when asked about equality of healthcare among minority participants. In their explanations, participants clarified the score as a 'middle' rating and did not agree with the statement that all individuals receive the same level of health care.

Seven (78%) mothers of White children reported that not all healthcare treatment is equal for individuals of minority racial background or non-English speakers. When asked to expand on ratings given, participants responded in a variety of ways. Lisa, a mother of Black children remarked, "They might treat you different if you're Hispanic, they might treat you different if you're African-American, they might treat you different if you're a Jew; just different things." When Emily, a White mother of a White child, rated the survey statement a 4, she gave this reason:

I've had no issues with my providers. I always felt that they listened to me. I had confidence in them, but I know for African American women and Latin American women in the United States, I think they have... Their mortality rate in childbirth is like three or four times higher than that of Caucasian women. And it's interesting, like they're... When they express pain or symptoms that they're having, like doctors tend to downplay their level of pain and the kind of toxic racism that they experience impacts their maternal well-being. So that's kind of a personal... On a personal note, just because I am privileged to have had the experience I have because of my ethnic background.

Five mothers of White children (56%) mentioned language as a barrier and one mother of a minority child (10%) specifically addressed language as a factor in healthcare discrimination. When asked to rate the statement, Marissa, a White mother of a Hispanic child, noted language as a barrier more so than race. She gave a rating of 2 for the assessment of healthcare discrimination and commented on the lack of Spanish-speaking medical providers in Kankakee, Illinois. She said, "I think I would probably say that's due more to maybe not ethnicity but just language."

Marissa, though she does speak Spanish and has Hispanic children, has never perceived discrimination due to language or racial factors. Perceived bias due to language goes beyond the scope of this study. This study's sample does not reflect perceived racial bias due to language barriers, and thus, no conclusions about such discrimination can be made.

Perceived General Discrimination

Perceived general discrimination was measured by asking each participant, "How much discrimination against minorities do you feel there is in the United States today?" All mothers of minority children (100%) gave a rating of 3 or 4, when a rating of 4 meant "a lot." The mean ratings given by mothers are recorded in Table 2. One mother of a Black child reported, "a lot of how we treat people in this country is still based upon how they look." One participant, a White woman with Black children, referenced minority representation when asked this survey question. Her daughter, when watching the Macy's Thanksgiving Day parade, said, "Why are there no brown people

like me dancing?” Her mother did not know how to answer why there was not more diversity represented.

In Campesino et al.’s study of 39 minority women, 77% reported perceiving bias against minorities in the United States today (2012). The present study’s minority participants perceived general discrimination at a higher rate. However, this difference cannot be necessarily attributed to higher levels of perceived bias due to the difference in sample size (n=10 versus n=39).

Of the other White participants with White children, four (46%) gave lower ratings of perceived minority discrimination (1 or 2). Such ratings were accompanied with statements like, “I feel like it has blown highly out of portion. I would honestly say that I believe it would be more along the lines of a two.”

One mother of a White child reported “some” discrimination in the United States today but remarked:

I think a lot of people like to stir up the race card and use that to their advantage, if they feel like they don’t get what they want. But in general, I think that everyone in an employee standpoint, is taught to treat people respectfully and if they’re not, then that’s their own ... personal choice.

However, five mothers of White children (56%) perceived higher levels (ratings of 3 or 4) of minority discrimination in the United States today. When asked to expand on answers, two mothers of White children noted that levels of discrimination vary based on location. Both of these participants compared their experiences in larger cities in the United States to their current location, Kankakee, Illinois. In larger cities, they perceived lower levels of minority discrimination, but higher rates in Kankakee. One mother described Kankakee County as more rural and less diverse. She remarked:

Yeah, when I first moved out here, ‘cause I grew up multi-cultural. I was the minority where I grew up in, very Asian-populated, Indian-populated. I was probably in the 17th percentile of Whites in my school I went to. So, when I first moved out here, went to a library, one of the librarians said, “Oh, those illegals” and I was like, “Whoa!” Or they used the terms “Oriental.” Those are not professionally appropriate words to use, ever. Those would just be very derogatory comments.

Overall, within this study’s sample, general minority discrimination was reported at different rates between minority participants and White participants. White mothers of White children perceived, on average, lower levels of general discrimination than mothers of minority children.

CONCLUSION

Some surveyed mothers of minority children perceived racial bias and cultural misunderstanding in their adolescents' care in emergency rooms, and this study highlights the importance of qualitative research that gives voices to participants and their experiences. Though the majority of minority patients did not perceive low levels of care in their child's visit to the emergency room, it is important to consider those who have experienced racial bias, cultural misunderstandings, and racial differences in treatment. Their voices and experiences shed light on the negative assumptions that occur in healthcare, including pediatric care, today. Still, mothers of minority children rated levels of healthcare equality lower and general discrimination higher than White mothers despite them not having personally experienced mistreatment within their child's healthcare.

Though participants included mothers located in different geographical locations, this study is not representative of the United States in its entirety. As a result, these findings cannot be generalized to all minority and White populations. Additional limitations include possible differences in face-to-face interviews and phone interviews. The manner in which different interviews were conducted could have had an effect on responses, so future studies could be conducted solely face-to-face to control for variability.

This study focused on perceptions of racial bias in pediatric care, but both minority and White participants mentioned insurance as an influence in level of care provided in emergency room settings. Thus, future studies could explore perceived bias in healthcare as it pertains to types of insurance and whether perceptions differ between individuals of different races or ethnicities. Future studies could also include perceptions of children with special health care needs (CSHCN). Two minority participants had children with special healthcare needs, and both mothers noted feelings of nervousness when considering visiting emergency rooms due to their incapability to meet their child's healthcare needs. Language as a factor in healthcare discrimination could also be further investigated. Five mothers of White children identified language as a barrier, and one mothers of a minority child did so. However, language as a barrier in healthcare goes beyond the scope of this study, and thus, further conclusion cannot be made.

Though minority parents in this sample did not feel as though their child got lesser medical care due to race, it is important to note the instances of misunderstanding and assumption due to race. Their experiences and views on healthcare are important tools to guide necessary change among healthcare staff. For some of these mothers, their experience furthers the call for cultural and sensitivity training. Linda, a Black mother of Black children expressed:

I still think there are flaws in the healthcare system, and there is room for much improvement. But also, society does play a part in that, you know. When the kids present to the ER, along with their parents, of course parents are gonna be upset,

it's their child, but I think the ER staff, they all need to be educated in mental health, as well as cultural competency, because all cultures are going to be different. And then I think with them having some type of education it kind of takes away some of the biases and the stereotypes.

Further studies could be conducted on methods in which to reduce racial bias in health-care and how cultural misunderstandings can be effectively reduced. Though level of care was rated highly by all minority mothers, their views on healthcare were still impacted by perceptions of racial and cultural misunderstanding. Though this sample is not representative of the entire United States, the participant's experiences are crucial for recognizing racial bias and cultural misunderstanding in pediatric healthcare.

APPENDIX A

Semi- Structured Interview Guide

Follow-up questions included, "tell me more about that," "what was that experience like," etc.

1. Can you describe for me your children, age, why the child was in the ER (if you are comfortable with letting me know what they were treated for)?
2. Which emergency room where you in?
3. In thinking about your child's most recent visit to the emergency room, how would you rate the level of care your child received? (On a scale of 1 to 5 with 5 being the highest)
4. In thinking about the experiences your child had in the emergency rooms, have there been times when you felt your child was treated differently by doctors (and the other staff including nurses and receptionists)?
 - a. Can you describe what occurred for me?
5. Do you think if something were different about your child that they would get better care?
6. Have you ever felt that your child was negatively judged during a visit to the emergency room?
 - a. If so, what made you feel like your child was judged? Can you describe for the situation in which you felt that way?
 - b. How do you react when you feel like your child is negatively judged?

7. Do you think the emergency room doctors or nurses have ever misunderstood you and your child because of your race or ethnicity or something cultural about you?
8. How does your child's treatment by the emergency room staff impact your view of the healthcare system?
9. Do you have any suggestions on how we can address the differences of how children are negatively treated by emergency room staff?
10. How would you rate the following statement,
 - a. "Most people in the United States receive the same quality of health care regardless of their racial background or language spoken."
(1= strongly agree to 4= strongly disagree)
11. How would you rate the following question,
 - a. "How much discrimination against minorities do you feel there is in the United States today?" (1= none to 4= a lot)

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